## About the Patient

**Chad Beiler, D.C.** 8360 City Centre Dr, Ste 120, Woodbury, MN 55125

Name _____ Today's Date _____ Birthday _____ Age _____ Gender □ M □ F

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

□ Single □ Married □ Divorced □ Widowed Social Security Number _____

Your Employer _____ Type of Work _____

Email Address _____ _ Have you been to a chiropractor before? □ Y □ N

Emergency Contact/Phone # _____ Who referred you to our office? _____

Primary Doctor: _____ Clinic Name/Location _____

- ❑ I authorize the doctor or his staff to render care as deemed appropriate for me and/or my child.
- ❑ I understand that **I am responsible for all bills** incurred in this office.
- ❑ I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- ❑ Person responsible for this account if other than the patient: _____
- ❑ Information on the privacy of your Personal Health information is available at the front desk.
- ❑ For my balance my preferred method of payment is: □ Cash □ Check □ Credit Card

_____ _____

Patient/Parent Signature Date

## Reason for Seeking Care

PRESENT COMPLAINTS

1. _____ How long has this been an issue? _____

Is it □ Dull □ Sharp □ Ache □ Numb/Tingling □ Stabbing □ Constant □ Occasional □ Staying the same □ Getting worse

2. _____ How long has this been an issue? _____

Is it □ Dull □ Sharp □ Ache □ Numb/Tingling □ Stabbing □ Constant □ Occasional □ Staying the same □ Getting worse

3. _____ How long has this been an issue? _____

Is it □ Dull □ Sharp □ Ache □ Numb/Tingling □ Stabbing □ Constant □ Occasional □ Staying the same □ Getting worse

4. _____ How long has this been an issue? _____

Is it □ Dull □ Sharp □ Ache □ Numb/Tingling □ Stabbing □ Constant □ Occasional □ Staying the same □ Getting worse

5. Does your condition affect: □ Sleep □ Work □ Daily Routine □ Sitting □ Driving □ Other _____

_____

6. What makes you feel better? _____

7. What makes you feel worse? _____

8. What doctor(s) have you seen for this? _____

_____

9. Type of treatment: _____

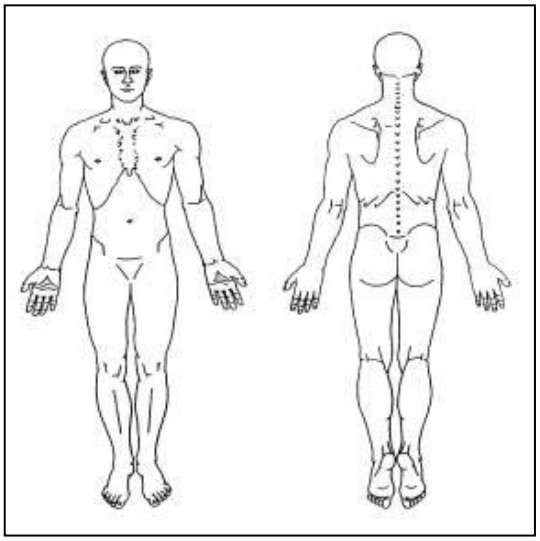
10. Results: _____

ADDITIONAL COMMENTS: _____

_____

_____

_____



Please mark all areas of concern.

## General Health History

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Patient Name _____ Mark the conditions that apply to you.

| Past | Present | | Past | Present | |
|---|---|---|---|---|---|
| □ | □ | Headaches | □ | □ | Urinary problems |
| □ | □ | Migraines | □ | □ | Easy bruising |
| □ | □ | Shortness of breath | □ | □ | Tobacco use |
| □ | □ | Allergies/Asthma | □ | □ | Dental problems |
| □ | □ | Medication side effects | □ | □ | Fibromyalgia |
| □ | □ | Diabetes | □ | □ | Blood thinner use |
| □ | □ | Hands or feet cold | □ | □ | HIV positive |
| □ | □ | Muscle aches | □ | □ | Cancer |
| □ | □ | Trouble walking | □ | □ | Depression |
| □ | □ | Leg/foot numbness | □ | □ | Alcohol use |
| □ | □ | Fainting | □ | □ | ___ High or ___ Low Blood Pressure |
| □ | □ | Gall bladder trouble | □ | □ | Stroke history |
| □ | □ | Ringing in ears | □ | □ | High cholesterol |
| □ | □ | Ear problems | □ | □ | TMJ |
| □ | □ | Sleeping problems | □ | □ | Digestive problems |
| □ | □ | Vision problems | □ | □ | Pain all over |
| □ | □ | Thyroid problems | □ | □ | Tension/irritability |
| □ | □ | Liver disease | □ | □ | Chest pains |
| □ | □ | Kidney problems | □ | □ | Heart pacemaker |
| □ | □ | Light bothers eyes | □ | □ | Heart problems |
| □ | □ | Other _____ | | | |

1. List any medications you are currently taking: _____
_____
_____

2. Has any doctor or other professional advised you to "go to a chiropractor"? □ Yes □ No

If so, referring doctor's name: _____

## Past History

1. List any past auto collisions: _____ Was any care received? _____
2. List any past work injuries: _____ Was any care received? _____
3. List any past sport, recreational, or home injuries: _____
4. Please describe any past conditions and treatment received: _____
_____
5. Please list any past hospitalizations and surgeries: _____
_____

## Family History

Father's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy medication use □ Arthritis □ Other _____

Mother's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy medication use □ Arthritis □ Other _____
Is there any other family history you want us to know? _____

## OFFICE FINANCIAL POLICY – effective June 1st, 2013

MN Spine & Sport
Treatment For The Sport of Life

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expense and allows you to place your family under care.

1. If you do **not** have insurance: **All payments are expected at the time of service or by an authorized payment plan**. **Your personal balance may not exceed $100 at any time or care may be terminated**. Our payment plans make care an affordable part of your family budget.

2. If you have insurance: All deductibles and co-payments are expected at the time of service or by an authorized payment plan. **Your co-insurance balance may not exceed $100 or care may be terminated**. Our payment plans make care an affordable part of your family budget.

You are considered a cash patient until you bring in your current insurance card, and we qualify and accept your insurance coverage. We do not accept assignment for secondary insurance carriers, but will be happy to provide you with a claim form for your secondary carrier.

Our fees are considered usual, customary, and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard and of care in this area.

If your carrier has not paid a claim in sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment.

If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

Patient's Printed Name: _____

Signature: _____ Date: _____

**For convenience, you may retain your credit card number on file with us.**

Card #: _____ Exp. Date: _____ CVV #:_____
Name as it appears on the card: _____
Cardholder's Signature_____